Appendix 4
Glossary

ACCOUNTS RECEIVABLE (A/R): An accounting system for recording activity pertaining to obligations incurred, payment made to providers within the Claims Processing Subsystem, which incorporates both manual and automated procedures. It reports current financial balances on individual providers and a history of transactions. Examples of A/R activity are:

1. Additional payments to providers who have been underpaid;
2. Recovery of payments to providers in accordance with approved procedures;
3. Advance (interim) payments to providers;
4. Returned provider checks

ACTIVITY RECORD: A claim service line from an input document that has additional information not contained on the original document (e.g., the Claim Control Number (CCN); a history of the Data Control Center (DCC); error codes; suspense codes; identifiers of persons assigning suspense or denial conditions).

ADDENDUM, CONTRACT: An addition or change made to the contract before the contract is signed into effect. The fiscal intermediary (FI) contract will include addenda added to the RFP.

ADDITIONAL CONTRACTUAL SERVICES (ACS): Proposed methods of providing contract services beyond those required in the RFP which will improve contract administration, including methods to improve the fiscal intermediary's performance through system improvements. ACS offers services, functions, procedures, or processes above requirements or current CD-MMIS functions. ACS may be offered for any areas of operation of the RFP or for those Department-required enhancements submitted for evaluation.

ADJUDICATED CLAIM SERVICE LINE (ACSL): The ACSL consists of all claim service lines included in this contract and any other health claims added to this contract adjudicated for all claim categories (approved for payment or denied) with exceptions (Payment Provisions, Adjudicated Claim Service Line Subsection) ACSL is a term whereby the reference is limited to Contractor payment.

ADJUDICATED ELAPSED TIME (AET): Total time elapsing in a single work session between the retrieval of the electronic facsimile of a pended document and the final adjudication routing.

ADJUDICATION STATUS: The status of a claim during claims processing. The status may be approved, suspended, or denied.

ADJUDICATION: A term, which refers to the final resolution of a claim or TAR in claims processing.

ADJUSTMENT, ACSL: A single annual adjustment made to the payment for administrative services to reconcile the prospective ACSL volume range payment to the actual ACSL volume for work performed.

ADJUSTMENT, AUDIT: Post-payment adjustment made by DHS to the amount payable to a provider, based on an examination of dental and/or financial data of the provider.

ADJUSTMENT, CLAIMS PROCESSING: A transaction that changes information on a previously adjudicated claim/NOA; e.g., payment amount, units of service, or other change to history. May be a debit, credit, or void adjustment.

ADJUDICATION CODE: A code specific to a claim service line reflecting the reason for modification or denial.

ADMINISTRATIVE BULLETIN: Bulletins released to potential bidders to answer questions that clarify RFP provisions.

AGED HISTORY: Claim history that is over thirty-six (36) months old (also referred to as Purged History), which includes all history records, including once-in-a-lifetime procedures and other records needed for service limitations.

AID: Cash assistance, food stamps, Medi-Cal, or other health care programs.

ALLOWABLE COST: Medi-Cal reimbursement rates to providers for services, as defined by regulation in Title 22 in the section related to Rates of Payment.

APPLICANT: All individuals seeking public assistance, including persons being added to an existing case and any other individual(s) whose income or resources are considered in determining the amount of benefits. The term applicant also applies to persons or entities seeking to become providers in the Medi-Cal program.

AUDIT: 1) The examination and verification of the Contractor's operation subject to the terms of this contract. 2) Validation checks made by the Contractor of a TAR, claim, or claim service lines against previously adjudicated claims or TARs, including claims or claim service lines adjudicated at the same time as the current claim (see AUDIT-COMPUTER).

AUDIT-COMPUTER: An automated examination of data on the claim/TAR/NOA in which the data is compared during process to applicable historical records and to other data on the claim, etc., for the purpose of determining claim/TAR and charge validity.

AUTOMATED ELIGIBILITY VERIFICATION SYSTEM (AEVS): An automated telephone voice response system that allows providers to verify a recipient's eligibility by using a touch-tone telephone. Providers are able to make inquiries regarding recipient eligibility by entering the beneficiary identification number from the face of the Benefits Identification Card (BIC). Responses to provider inquiries are generated using recorded voice messages.

BENEFICIARY: A person who has been determined eligible for public assistance, e.g., cash assistance, Medi-Cal, food stamps, CCS, GHPP, or CMSP. This term is used interchangeably with "recipient."

BENEFITS IDENTIFICATION CARD (BIC): A plastic card issued by DHS to each Medi-Cal recipient. Possession of a BIC is not proof of Medi-Cal eligibility because it is a permanent form of identification and is retained by the recipient even if he or she is not eligible for the current month. The dental office must verify eligibility of a beneficiary using the BIC at the time of services through the Medi-Cal automated eligibility verification system (AEVS). The BIC contains magnetic strip similar to that on a credit card and is designed to guide through a point-of-service (POS) machine, giving the dental office automatic access to patient eligibility information by viewing the AEVS read-out on the POS device.

BENEFICIARY ID NUMBER (BID): The fourteen (14)-digit identification number assigned to each Medi-Cal recipient by the county welfare department. The BID consists of a two (2)-digit county code, two (2)-digit alphanumeric aid code, seven (7)-digit alphanumeric serial/case number, one (1)-digit alphanumeric Family Budget Unit (FBU), and a two (2)-digit alphanumeric person number. All claims

history for a recipient, prior to the date of implementation of the SSN as primary ID enhancement, is filed under the first beneficiary ID number known to the claims processing system. Subsequent beneficiary ID numbers are cross-referenced to this initial ID or to the Permanent ID. See also Recipient ID and Permanent ID.

BENEFICIARY TOLL-FREE OPERATIONS: Contractor employees whose sole purpose is to perform work responsibilities are exclusively dedicated to telephone activities generated by beneficiary inquiries/complaints as defined in this RFP.

BENEFIT: Dental care services available to Medi-Cal, CMSP, CHDP, CTP, CCS/GHPP, and EPSDT beneficiaries.

BID: Document with price information submitted by bidder after their technical proposal has been determined acceptable.

BIDDER: A firm whose proposal passes the technical evaluation and who submits a bid in response to the Department's Invitation for Bid.

BI-MONTHLY: Every other month or once every two (2) months.

BI-WEEKLY: Every other week or once every two (2) weeks.

BOARD OF DENTAL EXAMINERS: The entity within the State Department of Consumer Affairs responsible for the licensing, regulation, and discipline of dentists.

BOTTOM LINE PRICING: Bottom line pricing compares the total Medicare paid on all of the lines on a crossover claim to the total of the Medi-Cal allowed amounts for all of the lines on the claim. Medi-Cal then pays any difference.

BUY-IN: An activity of the DHS Third Party Liability Branch, which coordinates and controls Medi-Cal payment of Medicare Part A and Part B premiums for eligible Medi-Cal beneficiaries.

CALIFORNIA CHILDREN'S SERVICES (CCS): The program, which provides specialized medical and dental services to financially and medically eligible children under the age of twenty-one (21) years who have severe medically handicapping conditions. The CCS program covers diagnostic, treatment, and therapy services.

CALIFORNIA ELIGIBILITY VERIFICATION AND CLAIMS MANAGEMENT SYSTEM (CA-EV/CMS): A non-mainframe system that includes on-line, real time processing of eligibility verification, share of cost, Medi-services, and pharmacy claims transaction using a POS device, AEVS, CERTS, Internet, or through approved user-developed/modified systems

AUTOMATED ELIGIBILITY VERIFICATION SYSTEM (AEVS) A voice response system that enables providers to perform eligibility, SOC, and Medi-Services transactions for Medi-Cal and CMSP recipients using a touch-tone telephone.

CALIFORNIA DENTAL MEDICAID MANAGEMENT INFORMATION SYSTEM (CD-MMIS): The certified California Dental Medicaid Management Information System, developed under federal guidelines, for the development and operation of California Medicaid processing and information retrieval. As a federally certified system, the CD-MMIS receives ninety percent (90%) federal funding for development and seventy-five percent (75%) federal funding for systems operation costs

(administrative) and fifty percent (50%) federal funding for pure premium. The CD-MMIS processes only dental claims.

CALIFORNIA MEDI-CAL MANAGEMENT INFORMATION SYSTEM (CA-MMIS): The certified California Medicaid Management Information System, developed under federal guidelines, for the development and operation of California Medicaid processing and information retrieval. As a federally certified system, the CA-MMIS receives ninety percent (90%) federal funding for development, seventy-five percent (75%) federal funding for systems operation, and fifty percent (50%) for claims payments on most federal/state covered services. The CA-MMIS processes all claims other than Dental.

CALIFORNIA POINT OF SERVICE (CALPOS): The Department's on-line, real-time pharmacy claims adjudication system, operated and maintained by the Department's FI (currently Electronic Data Systems Corporation).

CALPOS: See California Point of Service.

CAP: A method of health resource allocation in which a predetermined limit is set on the amount of health expenditures. See also CAPITATION FEE.

CAPITATED SERVICE: A service covered by a managed health care plan (HCP), thus not payable by fee-for-service (FFS). Providers must bill the HCP for reimbursement of capitated services. Duplicate FFS payment of capitated services is avoided via CD-MMIS edits and audits.

CAPITATION FEE: A single, fixed monthly amount paid to a provider or a managed care health plan. A fixed rate is paid per beneficiary, to cover a specified package of services, regardless of actual utilization. Also referred to as Capitation Rate.

CASUALTY INSURANCE: Auto, commercial, products, homeowner, and a variety of other insurance programs that generally have medical, dental and liability coverage. When Medi-Cal monies are paid for medical or dental services that are covered by casualty insurance, the federal law mandates the Department to seek recovery from the liable third party.

CATASTROPHIC INSURANCE COVERAGE: Health insurance, which provides protection against the high cost of treating severe or lengthy illnesses or disabilities. Generally such policies cover all or a specified percentage of medical or dental expenses above an amount that is the responsibility of the insured. When Medi-Cal monies are paid for medical or dental services, which are covered by casualty insurance DHS will seek recovery from the liable third (3^{rd}) party and set up an Accounts Receivable as appropriate.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) (formerly Health Care Financing Administration (HCFA): The federal government program that monitors the State Health care programs.

CERTIFICATION FOR MEDI-CAL RECIPIENT ELIGIBILITY: The determination by the county welfare department, the State, or the Social Security Administration, verified by DHS, that a person is eligible for Medi-Cal and either has no SOC, has met his/her SOC, or has a SOC which is less than the cost of long term care at the Medi-Cal rate.

CERTIFICATION, FEDERAL FINANCIAL PARTICIPATION (FFP): Approval by the Health Care Financing Administration of a Medicaid Management Information System for increased federal financial participation.

CERTS: See CLAIMS AND ELIGIBILITY REAL TIME SYSTEM.

CHANGE ORDER: The document and/or the process used by the State for funding additional responsibilities not inherent to the original or amended contract. Change orders are billed separately to the contract. This is a contract change resulting in changes to Contractor responsibilities and an adjustment to Contractor payment. A change order is distinguished from a contract amendment in that it is within the scope of the contract and is not a fundamental change to the nature of the contract, and does not require Contractor approval to implement).

CHARGES: The price assigned by the provider to a service rendered. Charges under different conditions may be construed as actual, allowable, customary, prevailing, reasonable and/or usual, depending on the reimbursement situation involved. Charge is to be distinguished from the actual cost of providing services and from the amount allowed by Medi-Cal.

CHECKWRITE: The function performed by the Contractor of printing and issuing, and mailing checks to providers.

CHILD HEALTH AND DISABILITY PREVENTION (CHDP): The program which provides health care assessments and screening of children under age twenty-one (21) for potentially handicapping conditions, and refers those needing additional services for diagnosis and treatment. This program is the California implementation of the federal Early and Periodic Screening & Diagnosis and Treatment Program (EPSDT) for Medi-Cal beneficiaries. The program also provides health care assessments for children under nineteen (19) years of age who are at or under two hundred percent (200%) of the Federal Income Guidelines.

CHILDREN'S TREATMENT PROGRAM (CTP): CTP treatment mandate which provides dental treatment for children under the nineteen (19) who meet CTP eligibility requirements; who are not covered by private health insurance, Medi-Cal without share of cost, California Children Services, or any other publicly funded program; who reside in specific CMSP counties. The CTP mandate states that counties which receive Proposition 99 funds for uncompensated care "shall provide, or arrange and pay for, medically necessary follow-up treatment, including necessary follow-up dental services and prescription drugs, for any condition detected as part of a Child Health and Disability Prevention screen for a child eligible for services" under the CHDP program. The legislation, which appropriated funds for this program, allows CMSP counties to contract back to the State to administer their CTP mandates.

CLAIM: A billing made on a claim form, computer media, or on a Notice of Authorization (NOA) returned by the provider with dates of services. Reference to a claim refers to the entire document.

CLAIM/FORM: Approved form used by a provider to request payment for non-prior authorized services rendered to Medi-Cal beneficiaries. The form includes all detail service lines (See Notice of Authorization).

CLAIM INQUIRY FORM (CIF): The form submitted by the provider to the fiscal intermediary to inquire about the status of a document in the system, request an adjustment of a previously paid claim, or to request a reconsideration of a denied claim or claim line.

CLAIM CONTROL NUMBER (CCN): The unique number assigned to each claim to identify it throughout processing.

CLAIM DETAIL REPORTS (CDR): Claims payment history records that are one (1) through seventy-two (72) months old.

CLAIMS AND ELIGIBILITY REAL TIME SYSTEM (CERTS): State-provided software, which allows providers to submit on-line eligibility, SOC, Medi-Services, pharmacy claims, and HCFA 1500, claims transactions.

CLAIM SERVICE LINE: A logical detail service line on a claim/TAR form or on a returned NOA that requests payment and contains a service code, a service description, a service fee and a service date.

CLAIM TYPE: Classification of a claim for billing purposes by origin or type of service provided to a recipient.

CLINICAL SCREENING DENTIST: A dentist hired by the Contractor to reexamine Medi-Cal recipients and present their findings/observations in the form of “second opinions”.

CMS: See Centers for Medicare and Medicaid Services.

CO-INSURANCE: A cost-sharing requirement under a health insurance policy that provides that the insured will assume a percentage of the costs of covered services. The policy provides that the insurer will reimburse a specified percentage of all or certain services above any deductible. The insured is then liable for the remaining percentage of costs until the maximum amount stipulated under the insurance policy is reached. Medicare requires a coinsurance under Part B and for specified services under Part A.

COMPUTER MEDIA CLAIM/DOCUMENT (CMC/CMD): Claims processing documents sent to and from the Fiscal Intermediary those are in machine-readable format on electronic media. CMCs include documents that are on magnetic tape/tape cartridge, diskette, or data transmitted over telephone lines.

COMPUTER OUTPUT MICROFILM (COM): Computer-generated micrographic images on either microfilm or microfiche.

CONTEXT DIAGRAM: Generalized tool to clarify the relationship of the CD-MMIS operations to external entities by delineating the domain of the system. It shows net inputs and outputs, but omits the details of the process within. Context diagrams may be expanded to serve as an "entity diagram" as well, i.e., to depict what documents or information are used, who is involved, and what is produced or accompanied.

CONTRACT EFFECTIVE DATE: The date upon which the terms of the contract go into force. Date is specified in the contract on the standard contract form.

CONTRACT REQUIREMENT: Any service, deliverable or other duty, which the Contractor is, required to provide or perform under the terms of the contract.

CONTRACTING OFFICER: Refers to the State official responsible for managing the contract.

CONTRACTOR: The fiscal intermediary that processes and adjudicates provider TAR and claims on behalf of the State.

CONTRACTOR COST: The actual cost or expenses incurred by the Contractor to perform any task as part of the contract. Certain Contractor bid prices are required to be based upon Contractor costs.

CONTRACTOR REPRESENTATIVE: Refers to the Contractor's Official responsible for managing the Contractor's operation.

CONTRACTOR WORKDAY: Any day the Contractor is open for business.

COORDINATION OF BENEFITS: The process of utilizing third party liability resources to ensure that the Medi-Cal program is the payer of last resort. This is accomplished by operating a cost avoidance method of paying claims, when the existence of Medicare or private dental coverage is known at the time the claim is processed, or the method of post payment recovery of the cost of services, if the coverage is identified retroactively.

CO-PAYMENT: A type of cost sharing whereby insured or covered persons pay a specified flat amount per service or type of service with the insurer paying the rest. Co-payment is incurred at the time of the service and is collected by the provider. Currently, co-payment for Medi-Cal services is not mandatory.

CORRESPONDENCE REFERENCE NUMBER (CRN): A control number assigned to all incoming provider correspondence, claims inquiry forms, appeals, high priority mail, and telephone calls. Assignment of a CRN initiates the controlling of correspondence from date of receipt to the closing of the case and generation of a response letter.

COST: 1) As it relates to providers, the expense incurred in delivery of dental care services; "cost" is distinguished from "charges." 2) As it relates to the Contractor, the expense or actual cost incurred by the Contractor to perform any task as part of the contract (see CONTRACTOR COST).

COST AVOIDANCE: A program requirement to bill the other health coverage and receive payment or proof of denial before submitting claims to Medi-Cal. It is the process of utilizing other coverage before billing Medi-Cal (42 CFR 433.139), (AS 3328: Margolin, Chapter 940 States of 1986).

COUNTY MEDICAL SERVICES PROGRAM (CMSP): In 1982, legislation was passed to transfer the Medically Indigent Adult (MIA) population, which was eligible under State-only Medi-Cal, to the counties. Those counties with a population of three hundred thousand (300,000) or less (as of the 1980 census) have the option, annually, to contract back with DHS to administer their MIA program. Of the fifty-eight (58) counties, forty-three (43) are eligible to contract back; however, only thirty-two (32) of the forty-three (43) eligible counties currently contract back with the State.

The contract-back MIA program administered by the State is known as the County Medical Services Program (CMSP), and the noncontract-back MIA program administered by the counties is known as the Medically Indigent Services Program (MISP). The MIA program is supported out of the State General Fund.

CMSP beneficiaries, individuals who are twenty-one (21) through sixty-four (64) years of age and who are not linked to Medi-Cal, are eligible for many of the same services as a Medi-Cal beneficiary with the exceptions.

CROSSOVER BENEFICIARY: A person who is entitled to coverage under both the Medicare and the Medi-Cal programs.

CROSSOVER CLAIM: A bill for services rendered to a crossover beneficiary. Medicare is billed first and pays for covered services less co-insurance and deductible or denies non-covered services. Medi-

Cal may then be billed and pays the residual up to Medi-Cal allowable amount for Medi-Cal covered services. The provider must re-bill Medi-Cal using Medi-Cal claim forms.

CUSTOMER INFORMATION CONTROL SYSTEM (CICS): Software monitor that interfaces between the application software and the on-line database.

DATA CONTROL CENTER (DCC): A unique identifiable manual or computerized station to which or from which documents may be routed during the adjudication process.

DATA ELEMENT DICTIONARY (DED): A database or file containing: a) database descriptions, both schema and subschema, and b) a system/collection of programs. Basically, it is a central storage facility for data definitions, programs/modules, documentation, and run-time information. CD-MMIS uses the product Integrated Data Dictionary (IDD). Refers to a collection of records, elements, sets, or areas.

DATA ENTRY: Method of entering data or information into the CD-MMIS from claim documents. Examples include: Optical Character Recognition (OCR), key-to-disc, tape-to tape, or via modem

DAY: The word "day" in the contract shall be a calendar day unless otherwise specified. (See also STATE WORKDAY)

DEDICATED STAFF: Staff that is solely assigned to perform work under a specified provision of the contract. Dedicated staff shall be strictly maintained at a level no less than that required in the RFP or proposed in the technical proposal, whichever is greater and shall be guaranteed at that level for the life of the contract. Dedicated staff and any changes thereto, shall be identified by name, in writing, and may not be committed by the Contractor to work activities outside the areas of the contract section designating them as dedicated staff without prior written approval of the Contracting Officer. The functions of these dedicated staff shall be adjusted based upon the work requirements of the Department

DEDUCTIBLE: The amount of loss or expense that must be incurred by an insured or otherwise covered individual before an insurer will assume any liability for all or part of the remaining cost of covered services. Deductibles are usually tied to some reference period over which they may be incurred, e.g., one hundred dollars ($100) per calendar year, benefit period, or period of illness.

DELIVERABLES: The specific product the Contractor is required to submit upon completion of a task or subtask. When the deliverable is intangible, documentation must be provided demonstrating completion.

DELTA DENTAL PLAN OF CALIFORNIA (DELTA): The current Fiscal Intermediary for the Medi-Cal Dental Program.

DENTI-CAL: term that is commonly used to refer to the Medi-Cal Dental Program. This program provides TAR/claim processing services, check issuance, utilization review, and control of dental claims for Medi-Cal recipients on a fee-for-service basis.

DENTAL OPERATING INSTRUCTION LETTER (DOIL): Document used to notify the Contractor of changes and clarifications to program policy, including instruction to the Contractor regarding changes required and language to be utilized by the Contractor in issuing provider bulletins or manual updates.

DENY: In document processing, to determine that a requested or billed service(s) is not allowable or payable because it does not meet Medi-Cal requirements for authorization or payment.

DEPARTMENT: In the contract, refers to the State of California Department of Health Services (DHS) and interchangeable with DHS.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS): The federal agency responsible for management of the Medicaid program.

DEPARTMENT OF HEALTH SERVICES (DHS): The single state agency responsible for administration of the Medi-Cal, CMSP, CCS, GHPP, and CHDP programs. It also has responsibility for other health-related programs administered through DHS. The Department acts for the State of California as the contract entity. Department/State actions are taken by the Contracting Officer or his or her designee. In the contract, Department and DHS are interchangeable.

DETAILED DESIGN SPECIFICATIONS: Those documents that contain the technical description of the configuration, components and operation of CD-MMIS.

DHS PROGRAMS: All programs currently administered by the Department of Health Services, or potentially to be administered by the Department under the contract resulting from this RFP and/or system change documents such as SDNs. These programs include those under which billing is made to the Medi-Cal FI for all Medi-Cal dental provider types currently billed to the CD-MMIS. Further, this includes such programs as CMSP, CHDP, CHDTP, CCS, and GHPP.

DISALLOW: Private insurance companies and government programs may not pay (may disallow) certain costs claimed by providers. Under private insurance, the patient may be responsible for picking up the difference. (Medi-Cal does not permit the provider to bill the patient except for recipient liability as defined by the State)

DISASTER: A sudden calamitous event bringing great damage, loss, or destruction.

DISKETTE: For purposes of the contract, a diskette, either three and one half inches (3 – ½ “) or compact disk (CD) in a density specified by the Department, for use on PCs.

DISPUTE: A controversy arising under the contract between the Department and the Contractor regarding the Contracting Officer's determinations concerning the terms and conditions and contractual obligations embodied in the contract.

DOCUMENT CONTROL NUMBER (DCN): A unique number assigned to each claim/TAR, used to identify the claim throughout processing. The number includes the Julian date of receipt by the Contractor.

DOWNTIME: The period of time that CD-MMIS is unavailable or "inhibited" to a State user or a State user terminal.

EARLY, PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROGRAM (EPSDT): A federal program that has been expanded by the State and is delivered through the State CHDP Program. This program screens children under age twenty-one (21) and refers those needing diagnosis and treatment for services. In about 1996 the EPSDT program became much larger in scope to embrace all treatment services for children under the age of twenty-one (21), even if such needed treatments are not specific in the State Plan.

EDIT: An examination in the claims processing subsystem of data on a document performed to ensure application of program policy. Edits include examination for such things as completeness and validity of data, recipient and provider eligibility, and necessity for manual pricing and dental consultant review.

EDITS/AUDITS: In the claims processing system, edits are performed daily to validate the document against validity requirements or CD-MMIS support files. Audits are performed daily to validate the document against history.

ELECTRONIC MEDIA DOCUMENT (EMD): Claims processing documents, sent to and from the FI, which are in machine-readable format on electronic media. EMDs include documents that are on magnetic tape, tape cartridges, diskette, or transmitted via modem.

ELIGIBILITY HISTORY FILE: A computer file maintained by DHS, which contains the current plus previous seventeen (17) months of eligibility status for all persons determined to be eligible for Medi-Cal benefits.

EMERGENCY SERVICES: Means dental care services rendered by an eligible Medi-Cal provider to a Medi-Cal beneficiary for any condition in which the beneficiary is in danger of loss of life, serious injury or illness, or is experiencing severe pain and suffering.

ENCOUNTER DATA: Encounter data is the record of a face-to-face delivery of a dental (or medical) service or supply by a managed care health care provider on a given date of service.

ENROLLMENT AND CERTIFICATION: The application process for a dentist who wishes to become a provider of services under the California Medi-Cal Dental Program.

ERRONEOUS PAYMENT CORRECTION (EPC): Refers to a re-adjudication of claims that share a set of specific parameters and were originally adjudicated improperly.

ESCROW ACCOUNT: The Escrow account holds all documentary information developed by the Contractor in preparation of bid prices for this procurement.

ESCROW BID DOCUMENTS: Escrow Bid Documents are those documents used to assist in the negotiation for the settlement of claims, in the resolution of disputes, and in Charge Order pricing. They will not be used for pre-award evaluation of the bidder's anticipated method of operation, or to assess the Contractor's qualifications for performing the work. The successful bidder agrees, as a condition of award of the contract, that the Escrow Bid Documents constitute all of the information used in preparation of the bid, and that no other bid preparation information will be considered in resolving claims. Nothing in the Escrow Bid Documents shall change or modify the terms or conditions of the contract. Escrow Bid Documents are due at the bid submission date.

EXCEPTIONAL PROCESSING INSTRUCTION (EPI): Directive by the Department to temporarily alter current processing procedures.

EXPANDED ACCESS TO PRIMARY CARE (EAPC): The purpose of the EAPC program is to improve the quality and expand the access of outpatient health care for medically indigent persons residing in under-served areas of California.

EXPANDED FUNCTION AUXILIARY: A person who may perform dental supportive procedures authorized by the provisions of the 1982 Dental Practice Act (see Section 1741(e), Article 7, Chapter 4, Division 2, Business and Professions Code).

EXPLANATION OF BENEFITS (EOB): This is the term previously utilized to describe the itemized list of all adjudicated claims by line item, reflecting any cutbacks and denials with an explanatory code and any accounts receivable activity. Also provides a listing of claims/TARs in suspense over eighteen (18) days.

EXPLANATION OF MEDICARE BENEFITS (EOMB): An itemized list of adjudicated claim lines issued by Medicare carriers. Copy must accompany all hard copy crossover claims submitted for Medi-Cal residual payment.

EXTERNAL QUALITY REVIEW GROUP (EQRG): A group of California School of Dentistry faculty members responsible for conducting annual reviews of the Contractor's Dental Consultants' professional judgment/decisions.

FACILITY: The physical building site(s) used by Contractor to perform CD-MMIS operations.

FAME: See FISCAL INTERMEDIARY ACCESS of MEDI-CAL ELIGIBILITY.

FEDERAL FINANCIAL PARTICIPATION (FFP): That portion of Medi-Cal funding provided by the Federal Government. The FFP must be matched by a varying percentage of State funds.

FEE-FOR-SERVICE (FFS): Reimbursement on a fixed-fee basis for each encounter or service rendered.

FEE SCHEDULE: A listing of established allowances for specified dental procedures. As used in Medi-Cal, it represents the maximum amounts the program will pay for the specified procedures. See also SCHEDULE OF MAXIMUM ALLOWANCES (SMA).

FILE: Used to describe 1) A collection of many occurrences of the same type of records commonly referred to as a data set. Entity type that refers to magnetic tape, cartridges, disk storage both sequential and direct access, and other non-database files. 2) Logical unit of database storage.

FISCAL INTERMEDIARY (FI): In California, a Contractor who performs Medi-Cal and other health program claims processing and management reporting functions for DHS.

FISCAL INTERMEDIARY ACCESS OF MEDI-CAL ELIGIBILITY (FAME): A file used by the FI to determine a patient's Medi-Cal eligibility. An abbreviated version of the MEDS (Medic-Cal Eligibility Data System) file.

FISCAL YEAR (FY): Any twelve (12)-month period for which annual accounts are kept. The State fiscal year is July 1 through June 30; the federal fiscal year is October 1 through September 30.

FIXED COSTS: Costs that do not change with fluctuations in enrollment, in utilization of service, or in Medi-Cal billings.

GENERAL SYSTEM DESIGN (GSD): The federal Title XIX (Social Security Act) standards against which a state's Medicaid system is compared for certification for increased levels of FFP.

GENERAL TERMS AND CONDITIONS: Specifies the term and requirements of the contract applicable throughout the life of the contract.

GENETICALLY HANDICAPPED PERSONS' PROGRAM (GHPP): The health program that provides medical services to persons with specific genetic conditions, such as hemophilia, cystic fibrosis, etc. GHPP clients must be twenty-one (21) years of age. Persons under that age are covered by California Children's Services (CCS). Persons under the age of twenty-one (21) with a specific GHPP eligible genetic condition may also be eligible for GHPP if they have first (1st) been determined financially ineligible to receive services from the CCS Program.

GEOGRAPHIC MANAGED CARE (GMC): A managed care program in specific counties. The GMC program is designed to provide a choice of managed care providers, all of which are expected to assure access to comprehensive primary care, preventive care, specialty care, and other necessary health services. Under the GMC, designated eligible medical beneficiaries residing in GMC counties are required to enroll in a health care service plan participating in GMC. Other designated Medi-Cal beneficiaries may voluntarily enroll in these plans under the GMC or remain in the FFS Medi-Cal delivery system.

GUARANTEED PER CAPITA PURE PREMIUM RATE: A single fixed monthly payment to the Contractor, for the number of persons eligible for Medi-Cal benefits each month. A fixed rate is paid per recipient to cover a specified package of services, regardless of actual utilization.

HCFA: See Centers for Medicare and Medicaid Serivces

HEALTH CARE FINANCING AND ADMINISTRATION (HCFA): See Centers for Medicare and Medicaid Services

HEALTH CARE PLAN (HCP): HCPs can be managed care capitated, FFS/MCN Pilot; or other health coverage (OHC). All three are treated uniquely in CD-MMIS, which uses the terms HCP (health care plan), managed care plan (MCP), and PHP (prepaid health plan) interchangeably. Unless the documentation specifically speaks to prepaid health plans, PHP, HCP, and MCP are one and the same for CD-MMIS purposes.

HEALTH and HUMAN SERVICES DATA CENTER (HHSDC): Formerly the Health and Welfare Data Center (HWDC). The HHSDC provides information systems infrastructure, support, and training for HHS Agency programs and related needs.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA): A federal law allowing persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II of this law gives the Department of Health and Human Services authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical, dental, and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers and employers; and to specify the types of measure required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Assebaum Bill, K2, or Public Law 104-191.

HEALTH MAINTENANCE ORGANIZATION (HMO): The term "health maintenance organization" is specifically defined in the Health Maintenance Act of 1973 (Public Law 93-222) as a legal entity or organized system of health care that provides directly or arranges for a comprehensive range of basic and supplemental health care services to a voluntarily enrolled population in a geographic area on a

primarily prepaid and fixed period basis. The term is sometimes used to denote any organized prepaid system; however, there are formal federal qualification procedures for official HMOs

HEALTHY FAMILIES (HF): The Healthy Families Program is a comprehensive health insurance plan for uninsured low-income children up to two hundred percent (200%) of the federal poverty level. The program is designed to enroll up to five hndred and eighty thousand (580,000) uninsured children of lower income working Californians who are ineligible for Medi-Cal. The program contracts with health care plans to provide comprehensive medical, dental, and vision services to HF enrolled children.

ID: Identification.

IMMEDIATE NEED MEDI-CAL IDENTIFICATION CARD: A paper Medi-Cal card produced by counties on an on-line printer, which allows a recipient's provider to verify eligibility and provide immediate-need medical services. Also given to minor consent recipients.

INTERACTIVE VOICE RESPONSE SYSTEM (IVR): Touch tone telephone system that providers may use as a primary source of checkwrite, claim and prior authorization information for services rendered through the Medi-Cal program.

INTERIM PAYMENTS: Special payments made in advance to providers, usually for unpaid claims that have been in the system due to Contractor or Department errors. These payments may be made only after evaluation on a case-by-case basis. Only DHS staff can authorize interim payments.

INTERNALLY REPROCESSED TAR NON-BILLABLE: A TAR that is reprocessed by the Contractor to allow processing of a subsequent TAR, due to a conflict in history.

INVALID CARD: A BIC card that contains illegible, erroneous or missing data elements.

INVITATION FOR BID (IFB): The second step in the "modified multi-step" procurement process. This document contains specific instructions for the calculation and presentation of price bids, so that all bids can be judged on an equivalent basis. Only proposers who have submitted acceptable technical proposals (Step One) are issued an Invitation for Bid.

JULIAN DATE: Julius Caesar adopted the Julian Calendar in 46 BC, consisting of a twelve (12)-month solar year of three hundred and sixty-five (365) days, with an extra day every fourth (4^{th}) year. A Julian Date is the number of the day of the year, where each day is numbered consecutively from one (1) through three hundred and sixty-five (365) (or 366); e.g., January 10 would be 010.

LETTER OF INTEREST: Letter sent to the OMCP by a potential proposer expressing interest in submitting a technical proposal and identifying the prime Contractor, address, liaison person(s), and any proposed subcontractor(s).

LINE ITEM (CLAIM): See CLAIM SERVICE LINE.

MAGNETIC MEDIA: A computerized form of data or information storage. Magnetic tape is an example of this form.

MAGNETIC TAPE/TAPE CARTRIDGE: All RFP references to magnetic tape and tape cartridge shall mean tape cartridge when referring to State and Contractor data exchanges. Tape cartridges must be useable in IBM 3480 Tape drives. The standard for all data exchanges between the Contractor and the State shall be tape cartridges unless the Contracting Officer approves the use of computer tapes.

MAKE AVAILABLE: Requirement that materials be available to appropriate personnel during normal business hours for both announced and unannounced review.

MANAGED CARE PLAN (MCP): Each MCP receives a monthly fee, or per capita rate, from the State for every enrolled recipient. Medi-Cal beneficiaries enrolled in contracting MCPs must receive Medi-Cal benefits from plan providers rather than the FFS program, unless the services are excluded from plan coverage. Recipients who are enrolled in Medi-Cal managed care plans fall into one of following managed care plan models:

1. Geographic Managed Care (GMC) – See GEOGRAPHIC MANAGED CARE

2. Prepaid Health Plans (PHP) – See PREPAID HEALTH PLANS

MANAGEMENT AND ADMINISTRATIVE REPORTING SUBSYSTEM (MARS): The CD-MMIS subsystem that is designed to generate reports for program management and system monitoring.

MANUAL OF CRITERIA FOR MEDI-CAL AUTHORIZATION (DENTAL SERVICES): The document which defines criteria per California Code of Regulations, Title 22 for the utilization of dental services under the California Medi-Cal Dental Program. It provides parameters to dentists treating Medi-Cal beneficiaries. It sets program benefits and clearly defines limitations, exclusions, and special documentation requirements.

MC177 - FACIMILE FORM: A Department approved form used to report Share-of-Cost.

MEASUREMENT ITEM (MI): Statistical indicators or parameters used for S/URS. Created by users to select data from the history files. Measurement items organize and manipulate history file data into a desired form or pattern. There are four (4) types of MIs: 1) S-Type, or Summary, which count every identified occurrence; 2) U-Type, or Unduplicated Count; 3) C-Type, or Compute, which are algebraic expressions and use other MIs; and 4) T-Type or Title, which merely give a subheading in a report to break up data.

MEDICAID: The federal medical assistance program enacted by the 1965 Title XIX amendments to the Social Security Act.

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS): A set of federally developed guidelines and requirements for development and operation of Medicaid claims processing and information systems.

MEDI-CAL: In California, the Title XIX Federal Medical Assistance Program (Medicaid) intended to provide federal and State financial assistance for health and medical, and dental care of needy persons meeting program eligibility standards.

MEDI-CAL CARD: In the past this was a computer printed or hand-typed card issued to a person certified to receive Medi-Cal benefits. The card identifies the person as a Medi-Cal beneficiary and provides other information necessary to show Medi-Cal entitlements: Medicare coverage, limited service status, private prepaid health coverage, long term care, Share –of Cost, etc. This has been replaced by a permanent plastic beneficiary identification card (BIC). (See also IMMEDIATE NEED MEDI-CAL IDENTIFICATION CARD, and BENEFICIARY IDENTIFICATION CARD.)

MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS): The automated eligibility information processing system operated by the State which provides on-line access to county welfare departments, Social Security offices, and health and human services staff throughout California. Major functions include benefits identification card issuance and update of recipient eligibility data. MEDS also maintains data on Medi-Cal health care plan enrollments and eligibility, private health insurance, Medicare, SOC, and Supplemental Security Income/State Supplemental Payments (SSI/SSP).

MEDI-CAL POINT OF SERVICE (POS) NETWORK INTERFACE SPECIFICATIONS: Formal document which details the dial-up communication specifications for accessing the Medi-Cal Point of Service (POS) Network, and the format for the data transactions and responses that will flow through the network. This network is used to support on-line real time transactions for eligibility verification, SOC clearance, Medi-Service reservations, Family Pact transactions, pharmacy drug claims, and HCFA 1500 claims submission, via dial-up for low-volume or lease-line for high volume.

MEDI-CAL POLICY: Medi-Cal Policy is defined in a number of documents including the California Statutes, Title 22, California Code of Regulations, Dental Operating Instruction Letters, Medi-Cal Dental Bulletin Updates, adopted Change Orders, the California Standard Nomenclature, the Dental Criteria Manual, Suspense and Error Handling Process, Professional and Paraprofessional Adjudication Manual, the Requirements Definition Manuals, and other CD-MMIS manuals.

MEDICALLY INDIGENT (MI): Persons previously eligible for Medi-Cal benefits not otherwise eligible for such benefits under the Public Assistance or Medically Needy Programs, because they did not meet the eligibility criteria for those programs. Most of the services provided under the adult portion of the MI program were one hundred percent (100%) State funded. Under legislation in 1982, responsibility for the MI over twenty-one (21) who are not in long term care facilities, or a woman of any age with a confirmed pregnancy, or a person under refugee medical assistance, was transferred to the counties. Some counties contract back to the State for payment of these services under the CMSP.

MEDICALLY NEEDY (MN): Persons who are determined to meet the eligibility criteria for cash welfare assistance in that they are aged, blind, disabled, or TANF-linked. However, they are disqualified for cash assistance because they refuse it, have excess earnings, income, or hours of employment, or are in long term care facilities. Some MNs have an SOC for their medical care.

MEDICARE: The federally financed program under Title XVIII of the Social Security Act, which provides health insurance primarily for the aged, sixty-five (65) and over. It also covers persons eligible for Social Security disability payments and for certain individuals who need kidney dialysis or transplantation.

1. PART A: Hospital Insurance Program - The compulsory portion of Medicare which automatically enrolls all persons aged sixty-five (65) and over; those entitled to benefits under OASDI or railroad retirement; persons under sixty-five (65) who have been eligible for disability for over two years; and insured workers (and their dependents) requiring renal dialysis or kidney transplantation. The program pays, after various cost-sharing requirements are met, for inpatient hospital care and care in skilled nursing facilities and home health agencies following a period of hospitalization. The program is financed from a separate trust fund funded with a contributory tax (payroll tax) levied on employers, employees and the self-employed. The Medicare program contracts with intermediaries to process claims under the program. The intermediaries determine amounts to be paid for claims based on set payment rates.

2. PART B: Supplementary Medical Insurance Program - The voluntary portion of Medicare in which eligible persons may become entitled to the services listed below. The program is financed from

monthly premiums paid by persons insured under the program and a matching amount from federal general revenues. About ninety five percent (95%) of eligible people are enrolled. During any calendar year, the program will pay (with certain exceptions), eighty percent (80%) of the reasonable charges (as determined by the program) for all covered services, after the insured pays a deductible on the costs of such services. Covered services include physician services, home health care, medical and other health services, outpatient hospital services, and laboratory, pathology and radiology services. Any individual over sixty-five (65) may elect to enroll in Part B Medi-Cal buys Part B coverage for elderly, blind and disabled public assistance recipients and pays the premiums, deductibles and coinsurance on their behalf. The Medicare program contracts with carriers to process claims under the program. The carriers determine amounts to be paid for claims based on reasonable charges.

MEDS: The Medi-Cal Eligibility Data System.

MEDS ID: The SSN or pseudo-SSN; used in the State Medi-Cal Eligibility Data System (MEDS) as the primary recipient identifier. In the CD-MMIS, the MEDS ID or pseudo-SSN assigned by the Contractor is the primary recipient identifier in the Contractor's system. The Medi-Cal label on computer issued cards has been changed to remove the fourteen digit BID and replace with the MEDS ID, a check digit, county code and the aid code.

MILESTONE: A significant point in development.

MODIFIED MULTI-STEP: A procurement process involving several separate steps.

MOST RECENT DOCUMENT CONTROL NUMBER (MRDCN): The document control number assigned to a Notice of Authorization (NOA) or Resubmission Turnaround Document (RTD) when each is returned to the Contractor for processing.

NEGATIVE BALANCE: A condition that can occur during a payment process when a provider has negative adjustments that exceed the amount of payment due him. The result is a "negative" balance for the provider.

NOTICE OF AUTHORIZATION (NOA): The document generated by the computer when a Treatment Authorization Request (TAR) is fully adjudicated. This document notifies the provider of the actions taken by the Contractor which is either to approve, modify, or deny Once the authorized services have been rendered, the provider adding service dates, provider signature or initials and returned to the Contractor as a claim for processing often referred to as a claim at this point completes the NOA.

NOTICE OF CLAIM: The contract provides that the Contractor may bring to the attention of the Contracting Officer, through specified procedures, a claim for adjustment to the price or performance schedule if the Contractor believes that an event or set of circumstances warrants such adjustment.

OASDI: Old Age, Survivors' and Disability Insurance.

ON ASSIGNMENT: An agreement in which a patient assigns to another party, usually a provider, and the right to receive payment from a third-party for the service the patient has received. Assignment is used instead of a patient paying directly for the service and then receiving reimbursement from public or private insurance programs. In Medicare, if a dentist accepts assignment from the patient, he must agree to accept the program payment as payment-in-full (except for specific coinsurance, co-payment and deductible amounts required of the patient). Where Medi-Cal has paid for care and a third party legal or contractual asset is available, Medi-Cal has first right to that asset.

ON REQUEST: A provision requiring the Contractor to provide, within state-defined timeframes, a specific product or service at the direction of the Contracting Officer as a part of the fixed-price contract. On-request reports are provided the next workday after request.

ON-LINE: A CD-MMIS function that allows the user (State or Contractor) to have terminal/CRT access to computer maintained files and/or reports. This access may be a read-only function or have update intent, as required.

OPTICAL CHARACTER RECOGNITION (OCR): A high-speed automated process in which machine-printed (and sometimes hand printed) words, letters, numbers and symbols are recognized and translated into computer processable information. Thus, data is entered into the computer without the necessity of key entry.

OTHER COVERAGE, OTHER HEALTH COVERAGE (OHC): The responsibility of insurers other than Medi-Cal to pay legal or contractual entitlements to health care. (W&I Code, Section 10020, et seq , and Section 14024.) Typically, the provider must bill the other health coverage before billing Medi-Cal. See also THIRD PARTY LIABILITY.

OVERRIDE: A manual exemption of a specific data element on a claim/TAR from the application of a prescribed edit/audit during suspense processing. No automated exemptions are allowed.

P FACTOR: Percentage of connected calls versus non-connected calls and/or busy signals.

PARAPROFESSIONAL: Person who is not a licensed dentist but who has experience in a dental office (or the equivalent) in the direct provisions of services to patients and have the ability to read and identify radiographs (e.g., dental assistant, register dental assistant, and dental hygienist).

PEER REVIEW: Generally, the evaluation by other members of the same specialty or profession of the appropriateness, effectiveness and efficiency of services ordered or performed by the provider under review.

PENDED CLAIMS: All claims within the automated system that have not reached final adjudication status. This includes suspended claims and claims approved but waiting checkwrite.

PER DIEM RATES: The daily rate established for a facility to provide specific and/or all-inclusive services to a Medi-Cal recipient. The rate is established through application of an approved reimbursement formula or by special negotiation.

PER CAPITA RATE: Same as CAPITATION FEE.

PERMANENT ID NUMBER: The ID number under which a recipient's complete claims history is filed or cross-referenced. At this time, the permanent ID is the beneficiary's first Social Security number known to the CD-MMIS: either the real SSN or the Contractor-issued pseudo-Social Security number.

PILOT PROJECT: By legislative mandate or under the provisions of the W&I Code, DHS establishes pilot projects to evaluate the feasibility and cost effectiveness of providing dental care through innovative delivery systems.

POINT OF SERVICE (POS) DEVICE (or T-7): Terminal/device used by providers to submit electronic eligibility, SOC, Medi-Services, FPACT, and pharmacy transactions to the FI. See also CALIFORNIA ELIGIBILITY VERIFICATION AND CLAIMS MANAGEMENT SYSTEM (CA-EV/CMS).

POINT OF SERVICE (POS) NETWORK: A network that enables providers to perform eligibility, SOC, and Medi-Services transactions for Medi-Cal and CMSP recipients using a POS (T7) device, Claims and Eligibility Real Time Software (CERTS), the Internet, or through approved user-developed/modified systems.

The eligibility verification systems will confirm or deny a beneficiary's eligibility; provide information on SOC, other coverage, and PHP status; and identify any service restrictions that have been placed on that recipient. Periodically, changes in the Medi-Cal program will require that the messages be modified, deleted or added. For example, a new service restriction might be added, or a health care plan's telephone number may change. Addition and deletion of health care plan numbers are also required.

POSTSERVICE PREPAYMENT REVIEW: A review by the FI for medical necessity and program coverage after service was rendered but before payment is made. Payment may be withheld or reduced if the service rendered was inappropriate.

POSTPAYMENT RECOVERY: A process to recover monies, which have been paid for a Medi-Cal recipient when that recipient was covered for that service by a liable third party. The Postpayment Recovery method is used when cost avoidance is federally excluded for persons with Other Health Coverage codes A, M, X, Y, or Z, for preventive pediatric services, and for the cost of services provided to persons who are retroactively identified with other health coverage.

PREPAID HEALTH PLAN (PHP): One type of managed care health care plan. An organized system of health care, which guarantees to provide one or more medical services for an enrolled group of people for a fixed, prepaid period payment. This term describes some programs that contract with DHS to provide services to Medi-Cal recipients on a prepaid basis. See also HEALTH CARE PLAN.

PRIOR AUTHORIZATION: See TREATMENT AUTHORIZATION REQUEST (TAR).

PROBLEM CORRECTION SYSTEM (PCS): A system that receives, process, tracks, and reports on all problem statements issued by the Department and/or Contractor.

PROFESSIONAL: A California-licensed dentist.

PROFESSIONAL REVIEW ORGANIZATION (PRO): Federally funded organizations charged with comprehensive and ongoing quality review of services provided under the Medicare and Medicaid programs.

PROFILE/PROFILING: A statistical description of program activity in accordance with State-defined parameters. The process is a method of detecting areas/instances of potential abuse or misutilization. Activity may be described for individual Medi-Cal program participants, a class of participants, or by diagnosis, or a dental provider.

PROOF OF ELIGIBILITY (POE): Verification that a beneficiary is certified eligible to receive benefits for a specific month.

PROPOSER: A firm that submits or plans to submit a technical proposal in response to the RFP.

PROVIDER: An individual or organization enrolled by the Medi-Cal dental program to provide certain services to Medi-Cal eligibles. In the contract, the Contractor performs the Provider Enrollment

functions, such as the distribution of enrollment forms, in accordance with Department policy and direction.

PROVIDER IDENTIFICATION NUMBER (PIN): PIN to be used to access the telephone response system on a touch-tone telephone. The PIN identifies the provider as an authorized user and is the first data requested by the network to locate checkwrite, claim, prior authorization and continuing care recipient information in the system.

PROVIDER MANUALS/BULLETINS: Provider manuals and/or provider bulletins contain information to providers regarding Medi-Cal dental procedures, policy, statutes and regulations. The provider manual is updated by bulletins that replace outdated pages with current Medi-Cal information.

PROVIDER MASTER FILE (PMF): The on-line file (database), which, contains a record for each dentist or dental group certified to provide services under the Medi-Cal fee-for-service program. The file also includes rendering providers, providers who are suspended from participation in the program, and those placed on special prepayment review, including special prior authorization review. The file is used in the daily payment of provider claims and for accomplishing various MARS and S/URS reporting.

PROVIDER RELATIONS ORGANIZATION (PRO): Contractor employees dedicated to this function, and whose sole purpose is and whose work responsibilities are exclusively dedicated to provider relation's functions. These functions include responses to provider inquiries via correspondences and/or on-site visits.

PSEUDO MEDS ID: A pseudo SSN is generated by the Medi-Cal Eligibility Data System (MEDS) when the MEDS user adds an individual to MEDS without a real SSN. It is nine digits in length, beginning with an eight (8) or nine (9) and ending with a "P."

QUALITY MANAGEMENT UNIT: Contractor employees who coordinate and conduct quality management activities for Contractor staff. They provide reactive measurement and reporting of system performance and proactive policy review and recommendations.

RECIPIENT: A person enrolled in and eligible for benefits under the Medi-Cal program. This term is used interchangeably with "beneficiary."

RECIPIENT ELIGIBILITY HISTORY FILE (REHF): This is the recipient file(s) and database used for claims adjudication, which the Contractor constructs from the State's Eligibility History File and MEDS update.

RECIPIENT ID NUMBER: The recipient ID number is used in the current contract to mean the recipient Social Security number (SSN) or pseudo SSN. It is the nine (9)-digit number assigned by the federal Social Security Administration (SSA) and required for all Medi-Cal eligibles. The State MEDS system will assign a pseudo SSN to recipients who have not yet been assigned a number by SSA or who are eligible to obtain one. The pseudo SSN is nine (9) digits in length, beginning with an eight (8) or nine (9) and ending with a "P." For purposes of locating recipient claims history prior to the current contract, the recipient ID was the beneficiary ID number assigned by the county. (See BENEFICIARY ID NUMBER.)

REMOTE JOB ENTRY (RJE): Submission of jobs through an input unit that has access to a computer through a data link.

REMITTANCE ADVICE DETAIL (RAD): An itemized list of all adjudicated claims by line-item, reflecting any cut-backs and denials with an explanatory code and any accounts receivable activity. Also provides a listing of claims in suspense over thirty (30) days. This is sent to all providers with claim activity.

REMOTE JOB ENTRY (RJE): Submission of jobs through an input unit that has access to a computer through a data link.

REPLACE AND SUBSTITUTE (R&S): Modifications of procedure codes submitted by the provider on the claim/TAR form. The Contractor may replace (modify) the submitted procedure code to another dental procedure code(s) using the guidelines specified in the Professional/Paraprofessional Adjudication Manual.

REQUEST FOR PROPOSAL (RFP): The document that describes to prospective proposers the requirements of the FI system, terms and conditions of the contract, and technical information.

REQUIREMENT, CONTRACT REQUIREMENT: Any service, deliverable, or other duty that the Contractor is required to provide or perform under the contract.

RESUBMISSION TURNAROUND DOCUMENT (RTD): The system generated document duplicating a suspended TAR or claims this is sent to the provider for corrections and/or additional information. It is then returned to the FI for processing.

RETROACTIVE RATE CHANGE: A readjudication of paid claims using a new rate, which may be necessitated by policy changes, budgetary statutes, lawsuits or other reasons. For the period covered by the rate change, the readjudication may result in either an increase, decrease or no change in the amount previously paid.

RUNNING CALENDAR YEAR: Period of time covering twelve (12) consecutive months beginning with a month and continuing through the twelve (12)-month period with no exceptions.

SCHEDULE OF MAXIMUM ALLOWANCES (SMA): A listing of procedure/ service codes with descriptions and a maximum reimbursement amount. Rates are determined by DHS and published in Title 22 of the California Code of Regulations.

SELF-DEALING: For purposes of the contract, the term “self-dealing” refers to a possible conflict between the Contractor's duty and self-interest. For example, self-dealing occurs if the Contractor prepares and submits claims for Medi-Cal providers to itself as the FI. In this circumstance, the Contractor's FI duty could require a decision against the shared interest of a provider-client. In addition, special knowledge gained as the FI could be used to benefit provider-clients to the detriment of the State.

SHARE-OF-COST (SOC): The monthly dollar amount, which Medi-Cal beneficiaries in certain aid categories must pay or obligate toward medical or dental services prior to becoming eligible for Medi-Cal benefits. Also called the "recipient liability."

SHORT-DOYLE PROGRAM: Community Mental Health Services, which are administered by the Department of Mental Health.

SPECIAL CLAIMS REVIEW (SCR): The process whereby a provider, identified as a program abuser, will have claims subject to manual review for those services previously "abused."

STATE: The State of California. The State acts through the Department of Health Services (DHS), with the Department as the contract entity, and through a single Contracting Officer. Several other State agencies work closely with the Contractor. Department actions referenced in this contract, such as Know-Keene licensure and various audit are performed by other State agencies and/or taken by the Contracting Officer or their designee.

STATE WORKDAY: Any day except Saturday, Sunday, or an officially recognized State holiday.

STATE WORKDAY HOURS: Any State Workday between the hours of 8:00 a.m. and 5:00 p.m., PST.

SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTARY PAYMENT (SSI/SSP): The eligibility program authorized by Title XVI of the Social Security Act for aged, blind, and disabled persons.

SYSTEM DESIGN DOCUMENTATION: See DETAILED DESIGN SPECIFICATIONS.

SYSTEM VARIANCE REPORTS (SVR): The document used by the Department to identify and communicate system problems to the FI during acceptance testing.

SYSTEMS DEVELOPMENT GROUP (SDG): See SYSTEMS GROUP.

SYSTEMS DEVELOPMENT NOTICE (SDN): The document used to notify the Contractor of development activities required of the Systems Group.

SYSTEMS GROUP (SG): Contractor employees who design, develop, and install state-required modifications to the CD-MMIS. They also are dedicated to processing erroneous payment corrections, doing emergency program maintenance, and working to final resolution the problem statements that require programming changes to the CD-MMIS.

SYSTEMS MAINTENANCE GROUP (SMG): See SYSTEMS GROUP.

T-7 or T-7Q Device: Point of Service (POS) device used by providers to submit eligibility, SOC, Medi-Services, FPACT, and pharmacy transactions.

TAPE CARTRIDGE: See MAGNETIC TAPE/TAPE CARTRIDGE.

TAR FORM: Form used by a provider to request prior authorization to render services to Medi-Cal beneficiaries. See TREATMENT AUTHORIZATION REQUEST.

TITLE 22: Title 22, Division 3, of the California Code of Regulations contains the rules and regulations governing the Medi-Cal program. These regulations define and clarify the provisions of state statute, chiefly the Welfare and Institutions Code.

TITLE XIX (19): That portion of the federal Social Security Act that authorizes the Medicaid program (Medi-Cal is California's Medicaid program).

TITLE XVIII (18): That portion of the federal Social Security Act that authorizes the Medicare program.

TITLE XXI (21): That portion of the federal Social Security Act that authorizes the Healthy Families program.

TOLL-FREE TELEPHONE STAFF: Contractor employees whose sole purpose and work responsibility are exclusively dedicated to telephone activities generated by beneficiary or provider inquiris complaints.

THIRD PARTY LIABILITY (TPL): The responsibility of an individual or entity, other than the Medi-Cal program, for the payment of all or part of the medical/dental incurred because illness, injury trama, disease, or disability sustained by a Medi-Cal recipient. This liability may result from fault or negligence of such third parties (e g., auto accidents or other personal injury casualty claims or work compensation appeals). The Department is responsible for follow-up and collection of third party liability payments where it has paid for related care.

TRANSMITTAL LETTER: Letter from proposer transmitting the technical proposal. The transmittal letter shall be on official business letterhead and signed by an individual authorized to legally bind the proposer.

TREATMENT AUTHORIZATION REQUEST (TAR): A request submitted by the dental provider for authorization to provide specified service(s) to a recipient. TARs are received and processed by the Contractor.

TURNOVER: The portion of the contract that constitutes the work requirements associated with the transfer of the CD-MMIS from the current Contractor at the end of the contract. Turnover and Runout are closely linked responsibilities.

USE: See UTILIZATION.

USER DOCUMENTATION: Contractor developed, State-approved formal instructions for the operation of the system and performance of contract duties.

UTILIZATION: Utilization is commonly examined in terms of patterns or rates of use of a single service or type of service. Measurement of utilization of all services in combination is usually done in terms of dollar expenditures. “Use” is expressed in rates per unit of population at risk for a given period.

VERIFICATION OF ELIGIBILITY: Eligibility for the California Medi-Cal dental program is determined by each social services office and reported to the State of California. The State, in turn, issues a Medi-Cal Identification Card (BIC) to beneficiaries. Beneficiary eligibility information is immediately available through the Medi-Cal automated eligibility verification system (AEVS). This system is updated daily based on information received from the State.

WEIGHTING: Method for assigning a relative proportion of the technical proposal score to plans and from the plans to criteria based on their importance and priority to the Department. These weights, and the maximum score allowed when added, will equal the total technical score available.

WELFARE AND INSTITUTIONS CODE (W&I): The California code of law, which includes the Medi-Cal Act.

WORK(ING) DAY: Any day the Contractor is open for business.

WORKERS'S COMPENSATION: An insurance against liability imposed on certain employers to pay benefits and furnish care to employees injured, and to pay benefits to dependents of employees killed in the course of or arising out of their employment.

WORRY CRITERIA: Established standards which, when exceeded, identify potential problem areas. Used in specific MARS Reports.